Dear New Patient,

We are sending you this letter to welcome you to our practice. If you are unable to make the scheduled appointment, please contact our office as soon as possible and we will be happy to work on finding a time that suits your schedule. Please feel free to add extra sheets for information that may not fit into the forms provided in this package.

Please complete and bring this new patient paperwork, a list of all medications you are currently taking, your insurance card(s), and copay if your insurance requires one.

Thank you for choosing our practice and we look forward to providing you with excellent care.

ETSU Physicians Infectious Diseases

General Directions

For GPS entries use the intersection of N State of Franklin and Lark Street instead of our address.

From North (i.e. Sullivan/VA counties)

Take I-26 East toward Johnson City. At exit 19, take ramp right for N State of Franklin Rd. Go approximately 2.7 miles. Pass Karing Hearts Cardiology; they have a large LED street sign. Turn right on dead-end Lark Street. Turn left into ETSU Physicians and Associates parking lot. Brick building with canopy.

From South (i.e. Unicoi/NC Counties)

Take I-26 E toward Johnson City. At exit 23, take ramp right for TN-91 toward Cardinal Park Stadium / Downtown / Johnson City. Turn left on E Market St. Bear left on W Market St. Pass Aldi's grocery store. Turn right on N State of Franklin Rd at SunTrust Bank. As you crest small hill past Waffle House and Publix get in the left hand turn lane. Turn left on dead-end Lark Street. Turn left into ETSU Physicians and Associates parking lot. Brick building with canopy.

From East (i.e. Carter/Johnson Counties)

Take 4-lane US-321 towards Johnson City. Turn left at McDonald's to get on W State of Franklin Rd. Pass Johnson City Medical Center. As you crest small hill past Waffle House and Publix get in the left hand turn lane. Turn left on dead-end Lark Street. Turn left into ETSU Physicians and Associates parking lot. Brick building with canopy.

From West (i.e. Greene County, Patients further west may want to take I-26 directions above)

Take 11E all the way to Johnson City. Turn left on N State of Franklin Rd (Taco Bell on the corner). As you crest small hill past Waffle House and Publix get in the left hand turn lane. Turn left on dead-end Lark Street. Turn left into ETSU Physicians and Associates parking lot. Brick building with canopy.

Patient Information

Last Name	First Name	Middle Name
Social Security #	Preferred 1st Name	Date Of Birth
Street Address		Unit #
City		State/Zip
Mailing Address (if different)		
Home Phone	Cell Phone	Primary ☐ Home ☐ Cell
Email	Primary Care Physician	

Race
Check all that apply
☐ American Indian
☐ African American
☐ Hispanic
☐ White
☐ Other

Marital Status
☐ Single
☐ Married
☐ Domestic Partner
☐ Widowed
☐ Divorced
☐ Other

Birth Gender
☐ M
☐ F

Identified Gender
☐ M
☐ F
☐ Other

Language
☐ English
☐ Spanish
☐ Other

Do You Need A Translator?
☐ Yes
☐ No

Emergency Contact

Last Name	First Name	Phone

Relation To Patient ☐ Spouse/Partner ☐ Parent ☐ Guardian ☐ Other/Specify

Employer Information

Employer	Title	Phone
Street Address	City	State/Zip

Pharmacy Information

Name	Phone
Address	

Health Insurance Information

Insurance Name		Effective Date
Subscriber/Policy/ID #		Group #
Subscriber Name (If Not Patient)	DOB (If Not Patient)	SSN# (If Not Patient)

Relation To Patient (if not self) ☐ Spouse ☐ Parent ☐ Guardian ☐ Other

I authorize the release of any medical information necessary to process this bill to my insurance company and request payment of benefits to ETSU Physicians Infectious Diseases. I acknowledge that I am financially responsible for the payment whether or not covered by my insurance. This authorization shall continue until such time as I revoke it in writing.

Signature _____ Date _____

Receipt of Privacy Notice

_____ Initials

I have been presented with a copy of this provider's Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice and subject to the following restriction(s) concerning my personal medical information, I agree to the disclosers named in the notice, ETSU Notice of Privacy Practices. I am aware that I can request a copy of the notice from any authorized personnel within ETSU Physicians Infectious Diseases.

No Show/Late Arrival Policy

_____ Initials

The policy of ETSU Physicians Infectious Diseases requires an advance notice for any appointment cancellations. Although many scheduling conflicts occur from time to time we ask that you please notify our office of any cancellation prior to your appointment time. A patient is considered to have missed an appointment should they fail to appear without prior notification. Patients arriving 15 minutes after your appointment time may be rescheduled at the provider's discretion. In order to provide the standard of care ETSU Physicians Infectious Diseases prides itself on, it is important that schedule appointments are not missed, without prior notification, which would allow us to reschedule the appointment at a more convenient time that suits your needs. Should you miss three (3) or more appointments in a 12-month period you can potentially be dismissed from our office including any future appointments with ETSU Physicians Infectious Diseases.

Teaching Physicians

_____ Initials

You will be seen by a physician who is a member of the faculty of the James H. Quillen of Medicine. These physicians are responsible for teaching medical students and residents (post graduate trainees). Our dual missions are to care for patients and teach students and residents. Not only will you see your own physician here but you may also be seen by one or more students, residents, and fellows. This is part of the mission of the College of Medicine. We believe this adds to the depth and level of care the patient receives as patients are seen by one or more physicians and discussed in detail. Several thousand patients receive their medical care through our office and enjoy helping our teaching programs. We are pleased with your willingness to participate in our teaching program. Your care shall encompass a team approach to health care with involvement of your physicians, fellows, residents, students and other medical trainees.

Consent to Discuss medical information

I give ETSU Physicians Infectious Diseases permission to discuss my medical treatment/care with the following person below including the release of any prescriptions while I am under the care of ETSU Physicians Infectious Diseases. This authorization will remain in effect unless revoked in writing by the patient. This release expires in one (1) year. Susan Fields patients: No psychotherapy notes will be provided except by the provider where allowed by law.

1 Last Name First Name Phone

Relation To Patient

2 Last Name First Name Phone

Relation To Patient

3 Last Name First Name Phone

Relation To Patient

☐ ETSU Physicians Infectious Diseases may not release any personal information except where allowed by law. Only check this box if you have left the above fields blank.

Signature _____ Date _____

Insurance authorization and Assignment

I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to ETSU Physicians Infectious Diseases for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignments of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance company claim. I permit a copy of this authorization to be sued in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

I hereby authorize ETSU Physicians Infectious Diseases to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. This authorization is valid as long as I am a patient at ETSU Physicians Infectious Diseases.

I am responsible for all financial obligations of health services for the patient and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collections costs and reasonable legal fees.

Signature _____ Date _____

Advanced Directives Information

Federal law requires that we give you information about your right to make advance health care decision. Right now, you may be able to make your own health care decisions. However, you may not always be able to make such decisions. By giving advance direction, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or reuse treatment for you.

You can leave advance directions about withdrawal of life support by executing a “living will”. A living will authorizes your health care provider and family to withdraw or withhold medical car which artificially prolongs life in the event the attending physician determines you have a terminal condition from which there is no reasonable expectation of recovery. You can also name a person to make medical treatment decisions for you by appointing someone to have e “durable power of attorney for health care”. This person Is allowed to make health care decision for you including life support decisions. It may also direct the attending physician with respect to donations of your organs. It is our policy to honor a patient’s health care decisions to the full extent required by law. You are NOT required to give advance health care directions in order to receive care at ETSU Physicians Infectious Diseases.

If you answered YES to either of the questions below, we need a copy of the documents in your medical chart in order to be sure that your wishes are honored. Please provide a copy at your next visit if you do not have them at this time.

Do you have a living will? ☐ Yes ☐ No

Do you have a durable power of attorney for health care? ☐ Yes ☐ No

Signature _____ Date _____

Controlled Substance Prescription Policy

Controlled substance overuse and abuse has become a major problem. Controlled substances include narcotic pain medications (including but not limited to Avanza, codeine, Dilaudid, fentanyl, hydrocodone, Kadian, Lortab, morphine, MS-Contin, oxycodone, OxyContin, Percocet, Tylox, and Vicodin), certain nerve medications (including but not limited to alprazolam, Ativan, diazepam, lorazepam, valium, Xanax,), and other medications. Many patients come to ETSU Physicians Infectious Diseases as new patients expecting our providers will prescribe these medications on the first visit. It is our policy not prescribe such medications except under the most extreme and well documented conditions. If you are on such medications and need to continue them, you need to make other arrangements to obtain such prescriptions. If this policy is not acceptable to you, you may cancel your new patient appointment and seek care elsewhere. Additionally, we may or may not prescribe such medications in the future. Each patient will be evaluated on a case-by-case basis once enough information is available to make a clear diagnosis. This generally includes reviewing previous medical records and performing appropriate tests. Even if another physician has chosen to prescribe such medication, this does not mean that we will continue those mediations. ETSU Physicians Infectious Diseases believes that it is not usually in the best interest of the patient to take addictive medication on a long term basis.

ETSU Physicians Infectious Diseases has developed this mutual agreement to pertain to the treatment of any medical conditions. I understand that the goal of treatment is to improve my functional ability and in so doing that sometimes narcotics, sedatives, and/or tranquilizers are required. These medications can lead to abuse and dependency despite their effectiveness when used correctly. Please initial the following policies.

____ I will not share or trade medication with anyone.

____ I will not ask for any mediation to be dispensed early. I will allow 72 hours for these medications to be filled.

____ I will take the medication only as prescribed. I will not adjust the dosage without first discussing these changes with my physician.

____ I will obtain my prescription refills only during regular office hours, not on weekends, or after office hours. I will only use one pharmacy for my prescriptions.

____ Once a prescription is written, I am responsible for all my pills. If they are lost, stolen, misplaced, or disappear for any reason, I will not ask for any medications early.

____ I will authorize my physician to cooperate with any and all authorities as these medications are monitored by governmental agencies.

____ I understand any altering of original prescriptions will result in dismissal. Failure to keep appointments except in an emergency may result in dismissal.

____ I agree to obtain my prescriptions related to my chronic medical conditions only from my PCP or another provider within the same office. If any other physician provides these same prescriptions, I will immediately update my physician or I may be dismissed from ETSU Physicians Infectious Diseases.

____ I will bring unused medications in for random pill counts and provide random drug screens when requested as these medications have abuse potential. I understand that because these medications have abuse potential, I will participate in any drug rehabilitation and detoxification programs that are advised for my health.

____ I understand that while taking these medications my ability to drive and operate machinery may be impaired. I release my physicians and ETSU Physicians Infectious Diseases of any and all liability stemming from my impairment.

____ I understand random drug test screens will be performed. If I am unable to give a sample when requested or that the detection of illegal substances or unauthorized medications are present I may be dismissed. If the results do not detect prescribed medications I may be dismissed.

By signing below, I acknowledge I have read and understand this policy regarding controlled substance prescriptions. I may request a copy of this agreement during ETSU Physicians Infectious Diseases business hours free of charge. Failure to comply with any of the above statements may result in my dismissal from this practice. You may cancel your new patient appointment without prejudice if you do not agree with the above policy.

Signature _____ Date _____

Hospitalization History

Illness/Surgery	Date	Illness/Surgery	Date

Known Allergies (Drug and Non-Drug Related)

Allergy	Reaction	Allergy	Reaction

Tobacco History

Do you smoke or chew tobacco? ☐ Yes ☐ No ☐ Quit

If yes, how much per day? If you quit, how long ago?

Alcohol History

Do you consume alcohol? ☐ Yes ☐ No ☐ Quit

If yes, how much per day? If you quit, how long ago?

Recreational Drug History

Do you use recreational drugs? ☐ Yes ☐ No ☐ Quit

If yes, what kind and how much? If you quit, how long ago?

Vaccination History

			Date				Date
Tetanus	☐ No	☐ Yes		Influenza	☐ No	☐ Yes	
Pneumonia	☐ No	☐ Yes		Other			
TB skin Test	☐ Positive ☐ Negative			Other			

Family Medical History

Please indicate if grandparent, parent, and/or siblings have or had any of the following health problems.

Illness	Relation	Living/Deceased	Illness	Relation	Living/Deceased
Heart disease			Glaucoma		
Stroke			Mental Illness		
High Cholesterol			Dizziness		
High blood pressure			Bleeding problems		
Diabetes			Hearing loss		
Cancer/type?			Kidney problems		
TB			Other		
Thyroid Disease			Other		

Patient Medical History

Please check all that apply currently or in your past medical history. ☐ No Known Medical Problems

Women's Health

Last menstrual period _____
Age of first menstruation _____
Age of last menstruation _____
Last Pap Smear Date _____
Last Mammogram Date _____
☐ Pregnancy
Number of pregnancies ____
Number of births _____
☐ Abnormal Pap Smear
☐ Breast Problems
☐ Menstrual Irregularity
☐ Ovarian Cysts
☐ Pelvic Infection/PID
☐ Recurrent Vaginal Infections
☐ Severe Cramps
☐ Other

Men's Health

☐ Erectile Dysfunction
☐ Prostate Problems
☐ Testicular Problems
☐ Other

Neurology

☐ Concussion/Head Injury
☐ Dizziness/Fainting
☐ Frequent Headaches
☐ Insomnia/Sleep Issues
☐ Migraines
☐ Neuromuscular Disorder
☐ Seizures/Epilepsy
☐ Weakness/Paralysis
☐ Other

Ear, Nose, And Throat

☐ Frequent Ear Infections
☐ Frequent Sore Throats
☐ Hearing Loss/Deafness
☐ Repeated Nosebleeds
☐ Seasonal Allergies
☐ Sinus Infections
☐ Tonsils/Adenoids Surgery
☐ Other

Mental Health

☐ ADHD/ADD
☐ Alcohol and/or Drug Abuse
☐ Anorexia and/or Bulimia
☐ Anxiety And Or Panic Disorder
☐ Depression
☐ Learning Disability
☐ Suicide Attempt
☐ Other

Gastrointestinal

☐ Constipation
☐ Gallbladder/Bowel Problems
☐ Hepatitis
☐ Hernia
☐ Special Diet
☐ Stomach Problems/Ulcers
☐ Other

Cardiovascular

☐ Chest Pain
☐ Heart Murmur
☐ High Blood Pressure
☐ High Cholesterol
☐ History Of Palpitations
☐ Other

Infections

☐ Chicken Pox
☐ Cold Sores
☐ Meningitis
☐ Mononucleosis
☐ Positive TB Skin Test
☐ Other

Musculoskeletal

☐ Arthritis
☐ Back/Disc Problems
☐ Fracture/Dislocations
☐ Scoliosis
☐ Other

Blood Disorder

☐ Anemia/Low Iron
☐ Clotting Disorder
☐ Sickle Cell Trait/Disease
☐ Other

Endocrine

☐ Diabetes
☐ Sudden Weight Change
☐ Thyroid Problem/Disease
☐ Other

Genitourinary

☐ Kidney Stones Or Disease
☐ Sexually Transmitted Infections
☐ Urinary Tract Infection
☐ Other

Dermatology

☐ Acne
☐ Eczema
☐ Psoriasis
☐ Other

Lungs

☐ Asthma
☐ Bronchitis Or Pneumonia
☐ Exercise-Induced Asthma
☐ Other

Eyes

☐ Eye Injury/Disease
☐ Other

Current Medications (Prescription, Over-The-Counter, and Supplements)

	Name	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			